STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K015	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAITHFUL FRIENDS HOME HEALTHCARE INC	326 E S MAIN ST GAS CITY, IN 46933

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS	G 000		

This visit was a federal home health complaint survey. This visit resulted in an Immediate Jeopardy and extended survey.

Complaint #: IN00099617 - Substantiated. Federal deficiencies related to the allegation are cited.

Survey date: January 3, 2012
Extended survey dates: January 4, 5, and 6, 2012

Facility: 003961

Medicaid Vendor: 200466510

Surveyor: Susan E. Sparks, RN PHNS
Marty Coons, RN PHNS

An Immediate Jeopardy was identified on 1/6/11. The facility was informed of the Immediate Jeopardy on 1/6/11 at 6:00 PM. The Immediate Jeopardy remained uncorrected at survey exit.

Faithful Friends Homehealth is precluded from providing home health aide training and competency evaluations for a period of 2 years beginning January 6, 2012, through January 6, 2014, for being found out of compliance with the Conditions of Pariticipation 42 CFR 484.10 Patient rights; 484.14 Organization, services, and administration; 484:18 Acceptance of Patients, Plan of Care, and Medical Supervision; 484.30 Skilled Nurse Services; and 484.36 Home Health Aide Services.

Quality Review: Joyce Elder, MSN, BSN, RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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G 000	Continued From page 1 January 11, 2012 This survey report has been modified as the result of an IDR on 2/23/12. je	G 000		
G 100	484.10 PATIENT RIGHTS This CONDITION is not met as evidenced by: Based on clinical record, complaint log, aide note to patient's child, ambulance run record and hospital record review, and interview, it was determined the agency failed to ensure there was resolution to a complaint filed by a family member in 1 of 1 complaints that resulted in patient harm with the potential to affect all the agency's patients (See G 107) and failed to ensure the confidentiality of the patients' medical information in 10 of 10 clinical records with the potential to affect all the agency's patients and clinical records stored in a utility building were safeguarded against loss and unauthorized use in 1 of 1 off-site storage building creating potential access for all records stored in the building (See G 111). The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 42 CFR 484.10: Patient Rights resulting in the potential harm to all 131 patients. These finding resulting in the determination that an Immediate Jeopardy existed. The immediate jeopardy was identified on 01/07/2012. The facility was notified of the Immediate Jeopardy on 01/07/2012 at 6 PM. The Immediate Jeopardy	G 100		1/16/12

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G 100	Continued From page 2 remained unremoved at the survey exit.	G 100		
G 107	484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint. This STANDARD is not met as evidenced by: Based on clinical record, complaint log, aide note to patient's child, ambulance run record and hospital record review and interview, the agency failed to ensure there was resolution to a complaint filed by a family member in 1 of 1 complaints that resulted in patient harm with the potential to affect all the agency's patients. (#10) Findings: 1. Agency Complaint Form dated 11/4/11 included a complaint filed on 11/2/11 at 10 AM by the patient's family member's friend saying the home health aide (HHA) was negligent. The addendum is several pages of the aide sharing what she felt happened and two pages of what the agency felt what happened. The final conclusion was "We do not feel our aide was negligent. We do feel family failed to met their obligation as they had promised." The complaint log failed to show a resolution to the complaint. 2. Clinical record # 10, start of care 10/26/11,	G 107		1/16/12

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G 107	Continued From page 3	G 107		

included a plan of care with orders for skilled nursing (SN) 1-2 days a week, 1-2 hours a visit x 60 days and HHA 5-7 days a week 1-3 hours a visit 3-5 visits a day. The patient was diabetic The plan of care contained an order for the SN to monitor and assist with accuchecks PRN.

A. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home on 11/1/11 at 8 AM. The HHA note does not indicate care was different than the previous day.

B. An untimed nurses note dated 11/1/11 signed by SN, Employee T, states, "HHA informed writer that pt. [patient] is extremely confused, slurring her words, et very weak on R [right] side , so much so that she cannot hold her cup or fork. Writer called MD [medical doctor] et [and] son's girlfriend's cell phone. MD stated that the pt. did want to die @ [at] home, et that the MD would leave it up to the son as to if he wanted to take pt. to hospital, or let pt. die @ home. MD stated the only thing staff can do is to keep her comfortable. HHA also told writer that the pt. had brown urine et has an odor, et writer also informed MD of this too. MD gave no orders, other than to tell son what MD said. When writer contacted son's girlfriend, she stated she was leaving the store that she was shopping @ right then, et was leaving to tell pt's son what MD had said. Writer called HHA a little later to inform of MD decision, et HHA was talking with son's girlfriend when writer called, et stated that pt's son's girlfriend had already told her. Writer then started looking @ pt's med's [medications], et discovered that one of the med's. that the pt. was on could cause a stroke in elderly pt's with

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G 107	Continued From page 4	G 107		

dementia. Writer called MD office back et left message for MD about this finding. No call-back from MD has been received @ this time. Writer saw pt., et pt is exactly how HHA described. Assessment completed. When writer asked pt. if she wanted to go to hospital, pt appeared to think on it for a few seconds, then shook her head no. Writer still waited to see what pt's son decides to do with pt."

C. A untimed Change in Condition Oasis Comprehensive Assessment dated 11/1/11 evidenced Employee T, a Registered Nurse, did an assessment of the patient but did not check the patient's blood sugar level.

D. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home again on 11/1/11 at 1 PM. An addendum note indicated the patient was awake and talking with the son.

E. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home on 11/1/11 at 5 PM. A note the aide left for the son states, "Employee A was here 11-1-11 5 PM till 6 PM. Patient was sleep the whole hour. Patient was dry. Be back at 8 PM."

F. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home on 11/1/11 at 8 PM. The aide left a note for the family member that states, "11-1-11 was here @ 8 PM. Tried multiple times to wake patient up. Didn't succeed. did check patient's brief. Patient dry. But patient didn't have PM med's. Will be back at

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G 107	Continued From page 5 1 AM. Hopefully I can wake Patient then!" G. Patient's family member arrived at home around 9:15 PM and called the ambulance. The ambulance report states, "Patient's blood sugar checked at 13 mg/dl." H. Hospital documents from the emergency room states, "Comatose felt to be secondary to prolonged hypoglycemic event."	G 107		
G 111	484.10(d) CONFIDENTIALITY OF MEDICAL RECORDS The patient has the right to confidentiality of the clinical records maintained by the HHA. This STANDARD is not met as evidenced by: Based on clinical record and patient right document review and interview, the agency failed to ensure the confidentiality of the patients' medical information in 10 of 10 clinical records with the potential to affect all the agency's patients. (#1-10) Findings: 1. Faithful Friends Home Healthcare Notice of Privacy Practices, Effective: April 14, 2003, states, "This notice describes how medical information about you may be used and disclosed and how you ca get access to this information. Please review it carefully. ... Marketing Communications We may use and disclose your medical information to communicate with you about a product or service, to encourage you to purchase the product or service. ... Fund Raising We may use and disclose your medical	G 111		1/16/12

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G 111	Continued From page 6 information to contact you to raise funds for this agency. We may disclose your medical information to a business associate of Faithful Friends Home Healthcare (FFHHC) or a foundation related to FFHHC so that business associate or foundation may contact you to raise money for the benefit of FFHHC. We will only release demographic information, such as your name and address, and the dates you received treatment or services from FFHHC. If you do not want FFHHC or its foundation to contact you for fundraising, you must notify: FFHHC 326 E Main St. Gas City,IN 46993 in writing. FFHHC Directory We may include your name, your location in our facility, your condition described in general terms, and your religious affiliation in our directory while you are a client in our facility. ... If you do not want included in our facility directory, or you want to restrict the information we include in the directory, you must notify, FFHHC .... of your objection." 2. Clinical record 1 - 10 evidences a signed patient's rights and responsibilities form dated on the day of the patient's admission which included the above statement. 3. On 1/5/12 at 10 AM, confidential interview # 1 indicated the patient was unaware of the fundraising or the directory clause in the admission packet and had not been informed upon admission of this clause. 4. On January 7, 2011, at 6 PM, the Director of Nursing indicated she was unaware of this clause in the admission packet.	G 111		
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD	G 121		1/16/12

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G 121	Continued From page 7 The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Based on observation, the agency failed to ensure the staff followed infection control precautions in 2 of 5 home visits observed with the potential to spread infectious disease to all the agency's patients. (#1 and 2) Findings: 1. During a home visit to patient #1 on January 4, 2012, at 6 PM, the home health aide (HHA) was observed helping the patient into the shower. The HHA had two washcloths, one for the patient and one for the HHA. There were more washcloths available for use. The patient washed the face, upper body, legs and under the abdominal fold, then used the safety bar to stand and used the same washcloth to watch the peri area and around the indwelling catheter. The HHA did not offer a clean washcloth for the peri area. (Clinical record #1 identified the patient had frequent urinary tract infections.) After the bath, the HHA escorted the patient to the lift chair in the living room. The aide took the patient's blood pressure and recorded it in the family book. The aide gathered supplies for the blood sugar test. The aide did not sanitize her hands nor put on clean gloves. She rubbed the patient's finger vigorously and stuck the patient three times before getting a proper amount of blood for the test. The patients blood sugar was 200. The	G 121		

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G 121	Continued From page 8 aide recorded the result in the family book but did not inform her supervisor. 2. On January 4, 2012, at 3:10 PM during a home visit to patient #2, the licensed practical nurse (LPN) was observed flushing the bladder through a Monty button. The house was cluttered, had a cat odor, and hair of the cat everywhere. The LPN washed his hands and prepared the medicine to flush the bladder by mixing the medicine with sterile water and then drawing it into a sterile 60 cc syringe. The supplies came from the top of a very cluttered dresser. The LPN did not wear gloves. The LPN gloved without sanitizing his hands and opened the sterile external catheter kit. The LPN threw the tube of lubricant onto the dirty carpet. The patient was holding the non insertible end of the sterile catheter with a bare left hand. The LPN removed the left glove to get an alcohol swab and remove the bandage. He then cleaned around the opening. The LPN removed the right glove. Without sanitizing his hands, he donned new gloves. He inserted the lubricated end of the catheter into the bladder. He connected the end of the 60 cc syringe with the medicine to the end of the catheter the patient had been holding without cleaning the catheter. He infused the medicine into the catheter and did this several times until he got a bright yellow fluid with large particles return. He removed his gloves and taped the catheter to the abdomen without using gloves.	G 121		
G 122	484.14 ORGANIZATION, SERVICES & ADMINISTRATION	G 122		1/16/12

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G 122	Continued From page 9 This CONDITION is not met as evidenced by: Based on clinical record, complaint log, aide note to patient's child, ambulance run record, and hospital record review and interview, it was determined the agency failed to ensure the administrator directed the skilled nurse and home health aide to avert harm to a patient and future patients in 1 of 1 record reviewed in which there was patient harm with the potential to affect all the agency's patients (See G 133), and failed to ensure the skilled nurse and home health aide coordinated their efforts and continued to communicate in 1 of 1 record reviewed in which there was patient harm with the potential to affect all the agency's patients (See G 143 and G 144). The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 484.14: Organization, services, and administration potentially affecting all 131 of the agency's patients. These finding resulting in the determination that an Immediate Jeopardy existed. The immediate jeopardy was identified on 01/07/2012. The facility was notified of the Immediate Jeopardy on 01/07/2012 at 6 PM. The Immediate Jeopardy remained unremoved at the survey exit.	G 122		
G 133	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the	G 133		1/16/12

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G 133	Continued From page 10 group of professional personnel, and the staff. This STANDARD is not met as evidenced by: Based on clinical record, complaint log, aide note to patient's child, ambulance run record, and hospital record review and interview, the administrator failed to direct the skilled nurse and home health aide to avert harm to a patient and future patients in 1 of 1 record reviewed in which there was patient harm with the potential to affect all the agency's patients. (#10) Findings: 1. Agency Complaint Form dated 11/4/11 included a complaint filed on 11/2/11 at 10 AM by the patient's family member's friend saying the home health aide (HHA) was negligent. The addendum is several pages of the aide sharing what she felt happened and two pages of what the agency felt what happened. The final conclusion was "We do not feel our aide was negligent. We do feel family failed to met their obligation as they had promised." The complaint log failed to show a resolution to the complaint. 2. Clinical record # 10, start of care 10/26/11, included a plan of care with orders for skilled nursing (SN) 1-2 days a week, 1-2 hours a visit x 60 days and HHA 5-7 days a week 1-3 hours a visit 3-5 visits a day. The patient was diabetic The plan of care contained an order for the SN to monitor and assist with accuchecks PRN.	G 133		

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G 133	Continued From page 11	G 133		

A. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home on 11/1/11 at 8 AM. The HHA note does not indicate care was different than the previous day.

B. An untimed nurses note dated 11/1/11 signed by SN, Employee T, states, "HHA informed writer that pt. [patient] is extremely confused, slurring her words, et very weak on R [right] side , so much so that she cannot hold her cup or fork. Writer called MD [medical doctor] et [and] son's girlfriend's cell phone. MD stated that the pt. did want to die @ [at] home, et that the MD would leave it up to the son as to if he wanted to take pt. to hospital, or let pt. die @ home. MD stated the only thing staff can do is to keep her comfortable. HHA also told writer that the pt. had brown urine et has an odor, et writer also informed MD of this too. MD gave no orders, other than to tell son what MD said. When writer contacted son's girlfriend, she stated she was leaving the store that she was shopping @ right then, et was leaving to tell pt's son what MD had said. Writer called HHA a little later to inform of MD decision, et HHA was talking with son's girlfriend when writer called, et stated that pt's son's girlfriend had already told her. Writer then started looking @ pt's med's [medications], et discovered that one of the med's. that the pt. was on could cause a stroke in elderly pt's with dementia. Writer called MD office back et left message for MD about this finding. No call-back from MD has been received @ this time. Writer saw pt., et pt is exactly how HHA described. Assessment completed. When writer asked pt. if she wanted to go to hospital, pt appeared to think on it for a few seconds, then shook her head no.

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G 133	Continued From page 12 Writer still waited to see what pt's son decides to do with pt." C. A untimed Change in Condition Oasis Comprehensive Assessment dated 11/1/11 evidenced Employee T, a Registered Nurse, did an assessment of the patient but did not check the patient's blood sugar level. D. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home again on 11/1/11 at 1 PM. An addendum note indicated the patient was awake and talking with the son. E. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home on 11/1/11 at 5 PM. A note the aide left for the son states, "Employee A was here 11-1-11 5 PM till 6 PM. Patient was sleep the whole hour. Patient was dry. Be back at 8 PM." F. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home on 11/1/11 at 8 PM. The aide left a note for the family member that states, "11-1-11 was here @ 8 PM. Tried multiple times to wake patient up. Didn't succeed. did check patient's brief. Patient dry. But patient didn't have PM med's. Will be back at 1 AM. Hopefully I can wake Patient then!" G. Patient's family member arrived at home around 9:15 PM and called the ambulance. The ambulance report states, "Patient's blood sugar checked at 13 mg/dl."	G 133		

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G 133	Continued From page 13 H. Hospital documents from the emergency room states, "Comatose felt to be secondary to prolonged hypoglycemic event."	G 133		
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on clinical record, aide note to patient's child, ambulance run record, and hospital record review and interview, the agency failed to ensure the skilled nurse and home health aide coordinated their efforts and continued to communicate in 1 of 1 record reviewed in which there was patient harm with the potential to affect all the agency's patients. (#10) Findings: 1. Clinical record # 10, start of care 10/26/11, included a plan of care with orders for skilled nursing (SN) 1-2 days a week, 1-2 hours a visit x 60 days and HHA 5-7 days a week 1-3 hours a visit 3-5 visits a day. The patient was diabetic The plan of care contained an order for the SN to monitor and assist with accuchecks PRN. 2. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home on 11/1/11 at 8 AM. The HHA note does not indicate care was different than the previous day.	G 143		1/16/12

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G 143	Continued From page 14 3. An untimed nurses note dated 11/1/11 signed by SN, Employee T, states, "HHA informed writer that pt. [patient] is extremely confused, slurring her words, et very weak on R [right] side , so much so that she cannot hold her cup or fork. Writer called MD [medical doctor] et [and] son's girlfriend's cell phone. MD stated that the pt. did want to die @ [at] home, et that the MD would leave it up to the son as to if he wanted to take pt. to hospital, or let pt. die @ home. MD stated the only thing staff can do is to keep her comfortable. HHA also told writer that the pt. had brown urine et has an odor, et writer also informed MD of this too. MD gave no orders, other than to tell son what MD said. When writer contacted son's girlfriend, she stated she was leaving the store that she was shopping @ right then, et was leaving to tell pt's son what MD had said. Writer called HHA a little later to inform of MD decision, et HHA was talking with son's girlfriend when writer called, et stated that pt's son's girlfriend had already told her. Writer then started looking @ pt's med's [medications], et discovered that one of the med's. that the pt. was on could cause a stroke in elderly pt's with dementia. Writer called MD office back et left message for MD about this finding. No call-back from MD has been received @ this time. Writer saw pt., et pt is exactly how HHA described. Assessment completed. When writer asked pt. if she wanted to go to hospital, pt appeared to think on it for a few seconds, then shook her head no. Writer still waited to see what pt's son decides to do with pt." 4. A untimed Change in Condition Oasis Comprehensive Assessment dated 11/1/11 evidenced Employee T, a Registered Nurse, did an assessment of the patient but did not check	G 143		

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G 143	Continued From page 15 the patient's blood sugar level. 5. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home again on 11/1/11 at 1 PM. An addendum note indicated the patient was awake and talking with the son. 6. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home on 11/1/11 at 5 PM. A note the aide left for the son states, "Employee A was here 11-1-11 5 PM till 6 PM. Patient was sleep the whole hour. Patient was dry. Be back at 8 PM." 7. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home on 11/1/11 at 8 PM. The aide left a note for the family member that states, "11-1-11 was here @ 8 PM. Tried multiple times to wake patient up. Didn't succeed. did check patient's brief. Patient dry. But patient didn't have PM med's. Will be back at 1 AM. Hopefully I can wake Patient then!" 8. Patient's family member arrived at home around 9:15 PM and called the ambulance. The ambulance report states, "Patient's blood sugar checked at 13 mg/dl." 9. Hospital documents from the emergency room states, "Comatose felt to be secondary to prolonged hypoglycemic event."	G 143		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case	G 144		1/16/12

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conferences establish that effective interchange, reporting, and coordination of patient care does occur.

This STANDARD is not met as evidenced by:
Based on clinical record, aide note to patient's child, ambulance run record, and hospital record review and interview, the agency failed to ensure the skilled nurse and home health aide coordinated their efforts and continued to communicate in 1 of 1 record reviewed in which there was patient harm with the potential to affect all the agency's patients. (#10)

Findings:

1. Clinical record # 10, start of care 10/26/11, included a plan of care with orders for skilled nursing (SN) 1-2 days a week, 1-2 hours a visit x 60 days and HHA 5-7 days a week 1-3 hours a visit 3-5 visits a day. The patient was diabetic The plan of care contained an order for the SN to monitor and assist with accuchecks PRN.

2. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home on 11/1/11 at 8 AM. The HHA note does not indicate care was different than the previous day.

3. An untimed nurses note dated 11/1/11 signed by SN, Employee T, states, "HHA informed writer that pt. [patient] is extremely confused, slurring her words, et very weak on R [right] side , so much so that she cannot hold her cup or fork. Writer called MD [medical doctor] et [and] son's

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girlfriend's cell phone. MD stated that the pt. did want to die @ [at] home, et that the MD would leave it up to the son as to if he wanted to take pt. to hospital, or let pt. die @ home. MD stated the only thing staff can do is to keep her comfortable. HHA also told writer that the pt. had brown urine et has an odor, et writer also informed MD of this too. MD gave no orders, other than to tell son what MD said. When writer contacted son's girlfriend, she stated she was leaving the store that she was shopping @ right then, et was leaving to tell pt's son what MD had said. Writer called HHA a little later to inform of MD decision, et HHA was talking with son's girlfriend when writer called, et stated that pt's son's girlfriend had already told her. Writer then started looking @ pt's med's [medications], et discovered that one of the med's. that the pt. was on could cause a stroke in elderly pt's with dementia. Writer called MD office back et left message for MD about this finding. No call-back from MD has been received @ this time. Writer saw pt., et pt is exactly how HHA described. Assessment completed. When writer asked pt. if she wanted to go to hospital, pt appeared to think on it for a few seconds, then shook her head no. Writer still waited to see what pt's son decides to do with pt."

4. A untimed Change in Condition Oasis Comprehensive Assessment dated 11/1/11 evidenced Employee T, a Registered Nurse, did an assessment of the patient but did not check the patient's blood sugar level.

5. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home again on 11/1/11 at 1 PM. An addendum note indicated the patient was

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G 144	Continued From page 18 awake and talking with the son. 6. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home on 11/1/11 at 5 PM. A note the aide left for the son states, "Employee A was here 11-1-11 5 PM till 6 PM. Patient was sleep the whole hour. Patient was dry. Be back at 8 PM." 7. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home on 11/1/11 at 8 PM. The aide left a note for the family member that states, "11-1-11 was here @ 8 PM. Tried multiple times to wake patient up. Didn't succeed. did check patient's brief. Patient dry. But patient didn't have PM med's. Will be back at 1 AM. Hopefully I can wake Patient then!" 8. Patient's family member arrived at home around 9:15 PM and called the ambulance. The ambulance report states, "Patient's blood sugar checked at 13 mg/dl." 9. Hospital documents from the emergency room states, "Comatose felt to be secondary to prolonged hypoglycemic event."	G 144		
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER This CONDITION is not met as evidenced by: Based on clinical record, aide note to patient's child, ambulance run record, and hospital record review and interview, it was determined the	G 156		1/16/12

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G 156	Continued From page 19 agency failed to ensure the patient's needs were adequately met in the home in 1 of 1 record reviewed with patient harm resulting in the potential to affect all the agency's patients (See G 157), failed to ensure the skilled nurse made visits as ordered on the plan of care in 1 of 10 clinical records reviewed with the potential to affect all the agency's patients (See G 158), and failed to ensure the plan of care identified the patient was to have "comfort measures" and what those comfort measures were in 1 of 1 record reviewed of patients with patient harms resulting in the potential to affect all the agency's patients (See G 159). The cumulative effect of these systemic problems resulted in the agency being out of compliance with the Condition of Participation 484:18 Acceptance of Patients, Plan of Care, and Medical Supervision potentially affecting all of the agency's 131 patients. These finding resulting in the determination that an Immediate Jeopardy existed. The immediate jeopardy was identified on 01/07/2012. The facility was notified of the Immediate Jeopardy on 01/07/2012 at 6 PM. The Immediate Jeopardy remained unremoved at the survey exit.	G 156		
G 157	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence.	G 157		1/16/12

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G 157	Continued From page 20 This STANDARD is not met as evidenced by: Based on clinical record, aide note to patient's child, ambulance run record, and hospital record review and interview, the agency failed to ensure the patient's needs were adequately met in the home in 1 of 1 record reviewed with patient harm resulting in the potential to affect all the agency's patients. (#10) Findings: 1. Clinical record # 10, start of care 10/26/11, included a plan of care with orders for skilled nursing (SN) 1-2 days a week, 1-2 hours a visit x 60 days and HHA 5-7 days a week 1-3 hours a visit 3-5 visits a day. The patient was diabetic The plan of care contained an order for the SN to monitor and assist with accuchecks PRN. 2. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home on 11/1/11 at 8 AM. The HHA note does not indicate care was different than the previous day. 3. An untimed nurses note dated 11/1/11 signed by SN, Employee T, states, "HHA informed writer that pt. [patient] is extremely confused, slurring her words, et very weak on R [right] side , so much so that she cannot hold her cup or fork. Writer called MD [medical doctor] et [and] son's girlfriend's cell phone. MD stated that the pt. did want to die @ [at] home, et that the MD would leave it up to the son as to if he wanted to take pt. to hospital, or let pt. die @ home. MD stated the only thing staff can do is to keep her comfortable. HHA also told writer that the pt. had brown urine et has an odor, et writer also informed MD of this	G 157		

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G 157	Continued From page 21	G 157		

too. MD gave no orders, other than to tell son what MD said. When writer contacted son's girlfriend, she stated she was leaving the store that she was shopping @ right then, et was leaving to tell pt's son what MD had said. Writer called HHA a little later to inform of MD decision, et HHA was talking with son's girlfriend when writer called, et stated that pt's son's girlfriend had already told her. Writer then started looking @ pt's med's [medications], et discovered that one of the med's. that the pt. was on could cause a stroke in elderly pt's with dementia. Writer called MD office back et left message for MD about this finding. No call-back from MD has been received @ this time. Writer saw pt., et pt is exactly how HHA described. Assessment completed. When writer asked pt. if she wanted to go to hospital, pt appeared to think on it for a few seconds, then shook her head no. Writer still waited to see what pt's son decides to do with pt."

4. A untimed Change in Condition Oasis Comprehensive Assessment dated 11/1/11 evidenced Employee T, a Registered Nurse, did an assessment of the patient but did not check the patient's blood sugar level.

5. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home again on 11/1/11 at 1 PM. An addendum note indicated the patient was awake and talking with the son.

6. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home on 11/1/11 at 5 PM. A note the aide left for the son states, "Employee A was here 11-1-11 5 PM till 6 PM. Patient was sleep

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G 157	Continued From page 22 the whole hour. Patient was dry. Be back at 8 PM." 7. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home on 11/1/11 at 8 PM. The aide left a note for the family member that states, "11-1-11 was here @ 8 PM. Tried multiple times to wake patient up. Didn't succeed. did check patient's brief. Patient dry. But patient didn't have PM med's. Will be back at 1 AM. Hopefully I can wake Patient then!" 8. Patient's family member arrived at home around 9:15 PM and called the ambulance. The ambulance report states, "Patient's blood sugar checked at 13 mg/dl." 9. Hospital documents from the emergency room states, "Comatose felt to be secondary to prolonged hypoglycemic event."	G 157		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on clinical record review, the agency failed to ensure the skilled nurse made visits as ordered on the plan of care in 1 of 10 clinical records reviewed with the potential to affect all the agency's patients. (#10) Findings:	G 158		1/16/12

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G 158	Continued From page 23 1. Clinical record # 10, start of care 10/26/11, included a plan of care with orders for skilled nursing (SN) 1-2 days a week, 1-2 hours a visit for 60 days and home health aide (HHA) 5-7 days a week 1-3 hours a visit 3-5 visits a day for the certification period 10/26/11 to 12/24/11. The patient is diabetic. The SN may monitor and assist with accuchecks PRN. 2. The clinical record failed to evidence the skilled nurse made a visit until the 3rd day of the second week when the patient was having slurred speech. This was a PRN (if needed) visit. 3. A physician telephone order dated 10/31/11 states, "Start SN services today, 1-2 day/week, 1-2 hours/visit. Change plan of care recert period to 10/31/11 to 12/29/11." A physician telephone order dated 1/2/11 states, "SN did not do services the first week of admission, putting frequency out of range."	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure the plan of care	G 159		1/16/12

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identified the patient was to have "comfort measures" and what those comfort measures were in 1 of 1 record reviewed of patients with patient harms resulting in the potential to affect all the agency's patients. (#10)

Findings:

1. On 01-06-12 at 2:40 PM, employee A, a home health aide (HHA), indicated that during a routine home to patient #10 she was unable to awaken the patient. She then proceeded to check the patient for incontinence, completed peri-care, and turned the patient without the patient ever awakening. She then proceeded to the kitchen where she placed the patient's dinner back into the refrigerator and finished cleaning the kitchen. She then left the patient's family member a note and had noted the patient still had not awakened but was breathing. She then left the patient's home. Upon further questioning as to why she had not contacted her supervisor or called 911 when she was unable to awaken the patient, she indicated the supervisor had told her this patient case was for comfort measures only. When employee A was asked what comfort measures were in place she was unable to answer the question as she stated she did not know; she had not been told.

2. The plan of care (POC) for the certification period beginning 10/26/11 failed to identify only comfort measures were in place nor did the POC indicate any type of parameters for comfort measures.

3. On 01-06-12 at 3:10 PM, employee U, the director of nursing, indicated that the patient was

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G 159	Continued From page 25 dying and the doctor indicated that comfort measures were needed. Employee U indicated this was not documented anywhere in the patient's record. The agency did not have a policy or procedure in place on what comfort measures would be followed or practiced.	G 159		
G 168	484.30 SKILLED NURSING SERVICES This CONDITION is not met as evidenced by: Based on clinical record, aide note to patient's child, ambulance run record and hospital record review and interview, it was determined the agency failed to ensure the skilled nurse made visits as ordered on the plan of care in 1 of 10 clinical records reviewed with the potential to affect all the agency's patients (See G 170), the agency failed to ensure the registered nurse evaluated the patient's blood sugar when the patient had a change in condition in 1 of 1 patient record reviewed of patients that experienced patient harm with the potential to affect all the agency's patients (See G 172), failed to ensure the registered nurse utilized her nursing skill when the patient had a change in condition in 1 of 1 patient record reviewed of patients that experienced patient harm with the potential to affect all the agency's patients (See G 174), and failed to ensure the skilled nurse and home health aide coordinated their efforts and continued to communicate in 1 of 1 record reviewed in which there was patient harm with the potential to affect all the agency's patients (See G 176). The cumulative effect of these systemic problems resulted in the agency being out of compliance with the Condition of Participation 484.30 Skilled	G 168		1/16/12

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G 168	Continued From page 26 Nurse Services potentiality affecting all 131 patients of the agency. These finding resulting in the determination that an Immediate Jeopardy existed. The immediate jeopardy was identified on 01/07/2012. The facility was notified of the Immediate Jeopardy on 01/07/2012 at 6 PM. The Immediate Jeopardy remained unremoved at the survey exit.	G 168		
G 170	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on clinical record review, the agency failed to ensure the skilled nurse made visits as ordered on the plan of care in 1 of 10 clinical records reviewed with the potential to affect all the agency's patients. (#10) Findings: 1. Clinical record # 10, start of care 10/26/11, included a plan of care with orders for skilled nursing (SN) 1-2 days a week, 1-2 hours a visit for 60 days and home health aide (HHA) 5-7 days a week 1-3 hours a visit 3-5 visits a day for the certification period 10/26/11 to 12/24/11. The patient is diabetic. The SN may monitor and assist with accuchecks PRN. 2. The clinical record failed to evidence the skilled nurse made a visit until the 3rd day of the second week when the patient was having slurred speech. This was a PRN (if needed) visit.	G 170		1/16/12

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G 170	Continued From page 27 3. A physician telephone order dated 10/31/11 states, "Start SN services today, 1-2 day/week, 1-2 hours/visit. Change plan of care recert period to 10/31/11 to 12/29/11." A physician telephone order dated 1/2/11 states, "SN did not do services the first week of admission, putting frequency out of range."	G 170		
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. This STANDARD is not met as evidenced by: Based on clinical record, aide note to patient's child, ambulance run record and hospital record review and interview, the agency failed to ensure the registered nurse evaluated the patient's blood sugar when the patient had a change in condition in 1 of 1 patient record reviewed of patients that experienced patient harm with the potential to affect all the agency's patients. (#10) Findings: 1. Clinical record # 10, start of care 10/26/11, included a plan of care with orders for skilled nursing (SN) 1-2 days a week, 1-2 hours a visit x 60 days and HHA 5-7 days a week 1-3 hours a visit 3-5 visits a day. The patient was diabetic The plan of care contained an order for the SN to monitor and assist with accuchecks PRN. 2. An untimed nurses note dated 11/1/11 signed by SN, Employee T, states, "HHA informed writer that pt. [patient] is extremely confused, slurring	G 172		1/16/12

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G 172	Continued From page 28	G 172		

her words, et very weak on R [right] side , so much so that she cannot hold her cup or fork. Writer called MD [medical doctor] et [and] son's girlfriend's cell phone. MD stated that the pt. did want to die @ [at] home, et that the MD would leave it up to the son as to if he wanted to take pt. to hospital, or let pt. die @ home. MD stated the only thing staff can do is to keep her comfortable. HHA also told writer that the pt. had brown urine et has an odor, et writer also informed MD of this too. MD gave no orders, other than to tell son what MD said. When writer contacted son's girlfriend, she stated she was leaving the store that she was shopping @ right then, et was leaving to tell pt's son what MD had said. Writer called HHA a little later to inform of MD decision, et HHA was talking with son's girlfriend when writer called, et stated that pt's son's girlfriend had already told her. Writer then started looking @ pt's med's [medications], et discovered that one of the med's. that the pt. was on could cause a stroke in elderly pt's with dementia. Writer called MD office back et left message for MD about this finding. No call-back from MD has been received @ this time. Writer saw pt., et pt is exactly how HHA described. Assessment completed. When writer asked pt. if she wanted to go to hospital, pt appeared to think on it for a few seconds, then shook her head no. Writer still waited to see what pt's son decides to do with pt."

3. A untimed Change in Condition Oasis Comprehensive Assessment dated 11/1/11 evidenced Employee T, a Registered Nurse, did an assessment of the patient but did not check the patient's blood sugar level.

4. The "Faithful Friends Home Healthcare Home

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G 172	Continued From page 29 Health Aide" sheet evidenced the HHA (Employee A) went to the home again on 11/1/11 at 1 PM. An addendum note indicated the patient was awake and talking with the son. 5. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home on 11/1/11 at 5 PM. A note the aide left for the son states, "Employee A was here 11-1-11 5 PM till 6 PM. Patient was sleep the whole hour. Patient was dry. Be back at 8 PM." 6. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home on 11/1/11 at 8 PM. The aide left a note for the family member that states, "11-1-11 was here @ 8 PM. Tried multiple times to wake patient up. Didn't succeed. did check patient's brief. Patient dry. But patient didn't have PM med's. Will be back at 1 AM. Hopefully I can wake Patient then!" 7. Patient's family member arrived at home around 9:15 PM and called the ambulance. The ambulance report states, "Patient's blood sugar checked at 13 mg/dl." 8. Hospital documents from the emergency room states, "Comatose felt to be secondary to prolonged hypoglycemic event."	G 172		
G 174	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse furnishes those services requiring substantial and specialized nursing skill.	G 174		1/16/12

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G 174	Continued From page 30 This STANDARD is not met as evidenced by: Based on clinical record, aide note to patient's child, ambulance run record and hospital record review and interview, the agency failed to ensure the registered nurse utilized her nursing skill when the patient had a change in condition in 1 of 1 patient record reviewed of patients that experienced patient harm with the potential to affect all the agency's patients. (#10) Findings: 1. Clinical record # 10, start of care 10/26/11, included a plan of care with orders for skilled nursing (SN) 1-2 days a week, 1-2 hours a visit x 60 days and HHA 5-7 days a week 1-3 hours a visit 3-5 visits a day. The patient was diabetic The plan of care contained an order for the SN to monitor and assist with accuchecks PRN. 2. An untimed nurses note dated 11/1/11 signed by SN, Employee T, states, "HHA informed writer that pt. [patient] is extremely confused, slurring her words, et very weak on R [right] side , so much so that she cannot hold her cup or fork. Writer called MD [medical doctor] et [and] son's girlfriend's cell phone. MD stated that the pt. did want to die @ [at] home, et that the MD would leave it up to the son as to if he wanted to take pt. to hospital, or let pt. die @ home. MD stated the only thing staff can do is to keep her comfortable. HHA also told writer that the pt. had brown urine et has an odor, et writer also informed MD of this too. MD gave no orders, other than to tell son what MD said. When writer contacted son's girlfriend, she stated she was leaving the store that she was shopping @ right then, et was	G 174		

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G 174	Continued From page 31	G 174		

leaving to tell pt's son what MD had said. Writer called HHA a little later to inform of MD decision, et HHA was talking with son's girlfriend when writer called, et stated that pt's son's girlfriend had already told her. Writer then started looking @ pt's med's [medications], et discovered that one of the med's. that the pt. was on could cause a stroke in elderly pt's with dementia. Writer called MD office back et left message for MD about this finding. No call-back from MD has been received @ this time. Writer saw pt., et pt is exactly how HHA described. Assessment completed. When writer asked pt. if she wanted to go to hospital, pt appeared to think on it for a few seconds, then shook her head no. Writer still waited to see what pt's son decides to do with pt."

3. A untimed Change in Condition Oasis Comprehensive Assessment dated 11/1/11 evidenced Employee T, a Registered Nurse, did an assessment of the patient but did not check the patient's blood sugar level.

4. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home again on 11/1/11 at 1 PM. An addendum note indicated the patient was awake and talking with the son.

5. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home on 11/1/11 at 5 PM. A note the aide left for the son states, "Employee A was here 11-1-11 5 PM till 6 PM. Patient was sleep the whole hour. Patient was dry. Be back at 8 PM."

6. The "Faithful Friends Home Healthcare Home

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G 174	Continued From page 32 Health Aide" sheet evidenced the HHA (Employee A) went to the home on 11/1/11 at 8 PM. The aide left a note for the family member that states, "11-1-11 was here @ 8 PM. Tried multiple times to wake patient up. Didn't succeed. did check patient's brief. Patient dry. But patient didn't have PM med's. Will be back at 1 AM. Hopefully I can wake Patient then!" 7. Patient's family member arrived at home around 9:15 PM and called the ambulance. The ambulance report states, "Patient's blood sugar checked at 13 mg/dl." 8. Hospital documents from the emergency room states, "Comatose felt to be secondary to prolonged hypoglycemic event."	G 174		
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on clinical record, aide note to patient's child, ambulance run record, and hospital record review and interview, the agency failed to ensure the skilled nurse and home health aide coordinated their efforts and continued to communicate in 1 of 1 record reviewed in which there was patient harm with the potential to affect all the agency's patients. (#10) Findings:	G 176		1/16/12

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G 176	Continued From page 33	G 176		

1. Clinical record # 10, start of care 10/26/11, included a plan of care with orders for skilled nursing (SN) 1-2 days a week, 1-2 hours a visit x 60 days and HHA 5-7 days a week 1-3 hours a visit 3-5 visits a day. The patient was diabetic The plan of care contained an order for the SN to monitor and assist with accuchecks PRN.

2. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home on 11/1/11 at 8 AM. The HHA note does not indicate care was different than the previous day.

3. An untimed nurses note dated 11/1/11 signed by SN, Employee T, states, "HHA informed writer that pt. [patient] is extremely confused, slurring her words, et very weak on R [right] side , so much so that she cannot hold her cup or fork. Writer called MD [medical doctor] et [and] son's girlfriend's cell phone. MD stated that the pt. did want to die @ [at] home, et that the MD would leave it up to the son as to if he wanted to take pt. to hospital, or let pt. die @ home. MD stated the only thing staff can do is to keep her comfortable. HHA also told writer that the pt. had brown urine et has an odor, et writer also informed MD of this too. MD gave no orders, other than to tell son what MD said. When writer contacted son's girlfriend, she stated she was leaving the store that she was shopping @ right then, et was leaving to tell pt's son what MD had said. Writer called HHA a little later to inform of MD decision, et HHA was talking with son's girlfriend when writer called, et stated that pt's son's girlfriend had already told her. Writer then started looking @ pt's med's [medications], et discovered that one of the med's. that the pt. was on could cause

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G 176	Continued From page 34	G 176		

a stroke in elderly pt's with dementia. Writer called MD office back et left message for MD about this finding. No call-back from MD has been received @ this time. Writer saw pt., et pt is exactly how HHA described. Assessment completed. When writer asked pt. if she wanted to go to hospital, pt appeared to think on it for a few seconds, then shook her head no. Writer still waited to see what pt's son decides to do with pt."

4. A untimed Change in Condition Oasis Comprehensive Assessment dated 11/1/11 evidenced Employee T, a Registered Nurse, did an assessment of the patient but did not check the patient's blood sugar level.

5. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home again on 11/1/11 at 1 PM. An addendum note indicated the patient was awake and talking with the son.

6. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home on 11/1/11 at 5 PM. A note the aide left for the son states, "Employee A was here 11-1-11 5 PM till 6 PM. Patient was sleep the whole hour. Patient was dry. Be back at 8 PM."

7. The "Faithful Friends Home Healthcare Home Health Aide" sheet evidenced the HHA (Employee A) went to the home on 11/1/11 at 8 PM. The aide left a note for the family member that states, "11-1-11 was here @ 8 PM. Tried multiple times to wake patient up. Didn't succeed. did check patient's brief. Patient dry. But patient didn't have PM med's. Will be back at 1 AM. Hopefully

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G 176	Continued From page 35 I can wake Patient then!" 8. Patient's family member arrived at home around 9:15 PM and called the ambulance. The ambulance report states, "Patient's blood sugar checked at 13 mg/dl." 9. Hospital documents from the emergency room states, "Comatose felt to be secondary to prolonged hypoglycemic event."	G 176		
G 202	484.36 HOME HEALTH AIDE SERVICES This CONDITION is not met as evidenced by: Based on policy and procedure review, home health aide job description review, clinical record review, observation, and interview, it was determined the agency failed to ensure the home health aide was assigned to patients by a registered nurse for 6 of 10 clients receiving services from home health agency staff creating the potential for harm or imminent threat to all patients receiving home health agency services (See G 223), failed to ensure the home health aide instructions were prepared by the registered nurse for 6 of 10 clients receiving services from home health agency staff creating the potential for harm or imminent threat to all patients receiving home health agency services (See G 224), and failed to ensure the home health aide provided services according to agency policy and that were ordered by the physician for 2 of 2 home health aides reviewed creating the potential for harm or imminent threat to all patients receiving home health agency services (See G 176).	G 202		1/16/12

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G 202	Continued From page 36 The cumulative effect of these systemic problems resulted in the agency being out of compliance with the Condition of Participation 484.36: Home Health Aide Services. These finding resulting in the determination that an Immediate Jeopardy existed. The immediate jeopardy was identified on 01/07/2012. The facility was notified of the Immediate Jeopardy on 01/07/2012 at 6 PM. The Immediate Jeopardy remained unremoved at the survey exit.	G 202		
G 223	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide is assigned to a specific patient by the registered nurse. This STANDARD is not met as evidenced by: Based on clinical record review, the agency failed to ensure the home health aide was assigned to patients by a registered nurse for 6 (# 1, 4, 5, 6, 7, and 10) of 10 clients receiving services from home health agency staff creating the potential for harm or imminent threat to all patients receiving home health agency services. The findings include: 1. Clinical record 1, start of care (SOC) 10/19/10, included a plan of care with orders for home health aide services (HHA) for the certification period 11/18/11 to 1/16/11 (2012). The clinical record failed to evidence a current signed home health aide assignment sheet signed by the registered nurse (RN). 2. Clinical record 4, SOC 9/24/11, included a plan	G 223		1/16/12

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G 223	Continued From page 37 of care with orders for HHA services for the certification period 9/14/11 to 11/23/11. The clinical record failed to evidence a current signed home health aide assignment sheet signed by the RN. 3. Clinical record 5, SOC 1/21/11, included a plan of care with orders for HHA services for the certification period 10/16/11 to 12/14/11. The clinical record failed to evidence a current signed home health aide assignment sheet signed by the RN. 4. Clinical record 6, SOC 11/30/10, included a plan of care with orders for HHA services for the certification period 9/26/11-11/24/11. The clinical record failed to evidence a current signed home health aide assignment sheet signed by the RN. 5. Clinical record 7, SOC 9/1/11, included a plan of care with orders for HHA services for the certification period 10/31/11 to 12/29/11. The clinical record failed to evidence a current signed home health aide assignment sheet signed by the RN. 6. Clinical record 10, SOC 10/26/11, included a plan of care with orders for HHA services for the certification period 10/26/11 to 12/24/11. The clinical record failed to evidence a current signed home health aide assignment sheet had been completed and signed by the RN.	G 223		
G 224	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is	G 224		1/16/12

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G 224	Continued From page 38 responsible for the supervision of the home health aide under paragraph (d) of this section. This STANDARD is not met as evidenced by: Based on clinical record review, the agency failed to ensure the home health aide instructions were prepared by the registered nurse for 6 (# 1, 4, 5, 6, 7, and 10) of 10 clients receiving services from home health agency staff creating the potential for harm or imminent threat to all patients receiving home health agency services. The findings include: 1. Clinical record 1, start of care (SOC) 10/19/10, included a plan of care with orders for home health aide services (HHA) for the certification period 11/18/11 to 1/16/11 (2012). The clinical record failed to evidence a current signed home health aide assignment sheet signed by the registered nurse (RN). 2. Clinical record 4, SOC 9/24/11, included a plan of care with orders for HHA services for the certification period 9/14/11 to 11/23/11. The clinical record failed to evidence a current signed home health aide assignment sheet signed by the RN. 3. Clinical record 5, SOC 1/21/11, included a plan of care with orders for HHA services for the certification period 10/16/11 to 12/14/11. The clinical record failed to evidence a current signed home health aide assignment sheet signed by the RN. 4. Clinical record 6, SOC 11/30/10, included a	G 224		

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G 224	Continued From page 39 plan of care with orders for HHA services for the certification period 9/26/11-11/24/11. The clinical record failed to evidence a current signed home health aide assignment sheet signed by the RN. 5. Clinical record 7, SOC 9/1/11, included a plan of care with orders for HHA services for the certification period 10/31/11 to 12/29/11. The clinical record failed to evidence a current signed home health aide assignment sheet signed by the RN. 6. Clinical record 10, SOC 10/26/11, included a plan of care with orders for HHA services for the certification period 10/26/11 to 12/24/11. The clinical record failed to evidence a current signed home health aide assignment sheet had been completed and signed by the RN.	G 224		
G 225	484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. This STANDARD is not met as evidenced by: Based on policy and procedure review, home health aide job description review, clinical record review, observation, and interview, the agency failed to ensure the home health aide provided services according to agency policy and that were ordered by the physician for 2 (A and M) of 2 home health aides reviewed creating the potential for harm or imminent threat to all patients receiving home health agency services.	G 225		1/16/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K015	A. BUILDING _____ B. WING _____	C 01/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 225	Continued From page 40 The findings include: 1. The job description for a home health aide states, "Take vital signs when advised. Keep daily records and report incidents or changes to the nursing supervisor. These responsibilities include: observing clients, reporting facts and recording about the client's health and condition, carry out appropriate procedures and techniques ..." 2. On 01-06-12 at 2:40 PM, employee A, a home health aide (HHA), indicated that during a routine home to patient #10 she was unable to awaken the patient. She then proceeded to check the patient for incontinence, completed peri-care, and turned the patient without the patient ever awakening. She then proceeded to the kitchen where she placed the patient's dinner back into the refrigerator and finished cleaning the kitchen. She then left the patient's family member a note and had noted the patient still had not awakened but was breathing. She then left the patient's home. Upon further questioning as to why she had not contacted her supervisor or called 911 when she was unable to awaken the patient, she indicated the supervisor had told her this patient case was for comfort measures only. When employee A was asked what comfort measures were in place she was unable to answer the question as she stated she did not know; she had not been told. A. The patients plan of care (POC) for the certification period beginning 10/26/11 failed to identify only comfort measures were in place nor did the POC indicate any type of parameters for	G 225		

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G 225	Continued From page 41	G 225		

comfort measures.

B. The policy titled "Emergency Procedures" states, "In the event that the client becomes unconscious or the employee finds the client unconscious he/she should; Determine if the client is breathing and has a pulse, do not begin emergency procedures. If the client is breathing, has a pulse, but does not regain consciousness, call 911 immediately. Be prepared to give clients address and status. Stay with client until help arrives, and notify the nursing supervisor as soon as possible.

C. On 01-06-12 at 3:10 PM, employee U, the director of nursing, indicated that the patient was dying and the doctor indicated that comfort measures were needed. Employee U indicated this was not documented anywhere in the patient's record. The agency did not have a policy or procedure in place on what comfort measures would be followed or practiced.

3. On 01-06-12 at 2:25 PM, employee M, a HHA, indicated vital signs (VS) including blood pressure (B/P) are completed by the aide on most home visits. Employee M indicated the worksheet completed by the aides failed to have an area to record the VS and B/P taken. Employee M also indicated she often assisted with the patients having to test for blood sugars via finger sticks. The employee indicated she had no competency skills test for this; she just knew how to do it.

A. Employee M was observed performing with a finger stick on patient # 1 during a home visit on 1/4/11 at 6:10 PM.

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G 225	Continued From page 42 B. The patients POC for patient # 1 for the certification period 1/18/11 - 1/6/11 (2012) failed to evidence an order for the aide to complete VS and perform blood sugar monitoring. C. The HHA assignment sheet failed to include any orders for the HHA to perform blood sugar monitoring.	G 225		